STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 00 B. WING	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 6, 7, 8, 9, 13 and 14, 2012 Facility number: 000080 Provider number: 155160 AIM number: 100289330 Survey team: Leslie Parrett RN TC Sharon Lasher RN (February 7, 8, 9, 13 & 14, 2012) Barbara Gray RN Angel Tomlinson RN Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 14 Medicaid: 55 Other: 14 Total: 83 Stage 2 sample: 15 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review 2/21/12 by Suzanne Williams, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on interview and record review, the facility failed to give a detailed explanation for the reason residents were discharged from skilled services for 3 of 3 residents who met the criteria for liability notices and beneficiary appeal in a stage 2 sample of 15. (Resident # 31, # 47 and # 67) Findings include: 1.) Review on 2/13/12 at 10:00 a.m. of Resident # 31's discharge notice from skilled services, provided by the Office Manager, and dated 12/29/11, indicated the resident was discharged due to "the effective date coverage of your current Medicare Part A skilled services will end: 12/29/11." No further explanation was documented.	F0156	F-156 Notice of Rights, Rules, Services, Charges1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #31, #47, #67 were not affected by this alleged deficient practice. Corrected Notices have been made available. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents receiving skilled services have the potential to be affected by the alleged practice. The interdisciplinary team will be in-serviced on liabilty notices and beneficiary appeals by the ED on 3/6/12. Post test included. The ED is responsible to ensure compliance. Notices will contain explaination of discharges from skilled services.3) What measures will	03/15/2012

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	2.) Review on 2/13/12 at 10:00 a.m. of Resident # 47's discharge notice from skilled services, provided by the Office Manager, and dated 1/20/12, indicated the resident was discharged due to "the effective date coverage of your current Medicare Part A skilled services will end: 1/20/12." No further explanation was documented. 3.) Review on 2/13/12 at 10:00 a.m. of Resident # 67's discharge notice from skilled services, provided by the Office Manager, and dated 10/24/11, indicated the resident was discharged due to "the effective date coverage of your current Medicare Part A skilled services will end: 10/24/11." No further explanation was documented. On 2/14/12 at 2:30 p.m. interview with Business Office Manager indicated "no, we do not give a detailed explanation on discharge notices unless they ask for one, then they are provided with one." 3.1-4(a)		be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The interdisciplinary team will be in-serviced on liability notices and beneficiary appeals by the ED on 3/6/12. Post test included. The ED is responsible to ensure compliance and will review notices for approriate documentation prior to forwarding to families. Non-compliance will result in further education including disciplinary action.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The social service designee will monitor all discharges from skilled services notices daily x 4 weeks, bi-weekly x 2 months, monthly x 3 months and then quarterly for 2 quarters thereafter. Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to notify the physician and the resident's family of a diet change from regular to mechanical soft, for 1 of 15 residents	F0157	F-157 Notify of Changes1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #96 physician was notified of	03/15/2012

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	reviewed for physician notification, in the stage 2 sample of 15. (Resident #96) Findings include: 1.) Resident #96's record was reviewed on 2/8/12 at 12:07 P.M. Diagnoses included but were not limited to Alzheimer's type dementia with behavioral disturbance and atypical psychosis. Resident #96's significant change Minimum Data Set assessment dated 12/6/11, indicated she required supervision, encouragement, and cueing, with set up help only for eating. She had no difficulty chewing or swallowing. Resident #96's February, 2012 recapitulation physicians order indicated the following: 1/6/12-Regular diet. A nutrition care plan for Resident #96 indicated the following: 11/17/11-Problem-The resident is nutritionally at risk related to a diagnosis of Dementia. She has a poor appetite and weight loss. Goal-To maintain weight with no unexplained significant weight loss through the next review.		the down grade in diet and order is now in place and family has been notified.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The licensed nurses will be re-educated by the DNS/ designee (3/6/12) on obtaining speech therapy evaluation for a down grade in diet, physician notification of resident change in condition and obatin order to change diet, utilization of dietary communication form, and family notification of change with resident and notification of new orders. Physician will be notified of residents with change in condition for orders. Licensed nurse will fill out a dietary communication form when obtaining new diet order for daily review and verification of order in place by DNS/designee. All residents current dietary orders will be verified with tray card per DNS/designee and Dietary Manager to ensure appropriate and accurate. Review of all residents diets with orders by DNS and Dietary Manager. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The licensed nurses will be re-educated by the DNS/designee	

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	Approaches-Provide diet per MD order. Resident #96 was observed seated at the dining table with her peers on 2/8/12 at 12:20 P.M. She was served a mechanical soft diet which included noodles, peas, bread and butter, cake, and ground pork chop. Resident #96 was served thin milk and water with her meal. An interdisciplinary team note documented by LPN # 8 on 2/10/12 at 9:12 A.M., indicated the following: "IDT met to review resident's weight in nutrition at risk, due to weight loss. No problem chewing or swallowing. Receives a regular diet with 2 pieces of bread with each meal to enable resident to make sandwiches out of food. Resident consumes bites to 75% of meals with much encouragement from staff." Resident #96's tray card indicated the following: Mechanical soft diet. 2 Pieces of bread. Single serve dishes. An interview with the Dietary Manager on 2/13/12 at 2:39 P.M., indicated she reviewed the diet recommendations and orders for Resident #96 and could not find a physician's order for a mechanical soft diet. The Dietary		(3/6/12) on obtaining speech therapy evaluation for a down grade in diet, physician notification of resident change in condition and obtain order to change diet, utilization of dietary communication form, and family notification of change with resident and notification of new orders. Physician will be notified of residents with change in condition for orders. Licensed nurse will fill out a dietary communication form when obtaining new diet order for daily review and verification of order in place and family notification by DNS/designee. Speech therapy will be notified of all residents with down grade in diet for evaluation of resident. Residents with change in diet will be reviewed weekly in NAR for appropriateness of diet change and review of speech therapy recommendation. RD to reivew residents with diet change monthly.4) How the corrective action(s) will be monitored to ensure the deficient pactice will not recur: The CQI audit tool for Change in Condition will be utizied daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 months and for 3 quarters thereafter for any resident who has a change in condition requiring a diet change. Findings from CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what	

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	Manager indicated "probably what happened was me and a nurse discussed her diet and decided to try a mechanical soft to see if her intakes would improve, but we did not follow through with the order." The Dietary Manager indicated there was no documentation regarding the mechanical soft diet change for Resident #96 or why. The Dietary Manager indicated she did not know when Resident #96's diet was changed from regular to mechanical soft. An interview with the Dietary Manager on 2/14/12 at 9:37 A.M., indicated Resident #96 did not do well with meats on a regular diet, so she, and RN #7 decided to try the mechanical soft diet as a nursing measure, to see if Resident #96's intakes would improve. The Dietary Manager indicated she did not receive a physician's order for the diet change, and she did not notify Resident #96's husband. 3.1-5(a)(3)		date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow a physician's order for a regular diet and to leave a resident's dentures out to assist in healing mouth sores, and failed to transcribe a medication order for a resident when they returned from the hospital, resulting in the resident's mouth not being treated for mouth sores for 16 days, for 2 of 15 residents reviewed for physician's orders, in the stage 2 sample of 15. (Resident #96 and #20) Findings include: 1.) Resident #96's record was reviewed on 2/8/12 at 12:07 P.M. Diagnoses included but were not limited to Alzheimer's type dementia with behavioral disturbance and atypical psychosis. Resident #96's significant change Minimum Data Set assessment dated 12/6/11, indicated she required supervision, encouragement, and cueing, with set up help only for eating. She had no difficulty chewing	F0282	F-282 Services By Qualified Persons/Per Care Plan1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #96 physician was notified of the down grade in diet and order is now in place and family has been notified and in agreement. Resident #20 dentures are removed after meals per physician order with documentation of any resident refusals with family notification. Resident #20 orders have been reviewed and verified by licensed nurse and physician for accuracy and appropriateness.2) How other residents having the potential to be affected by the same deficient paractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by DNS/designee (3/6/12) on obatining physician orders and verification of orders, speech therapy evaluation with a diet down grade, dietary communication form, utilization of CNA assignment sheet and	03/15/2012

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	or swallowing. Resident #96's February, 2012 recapitulation physicians order indicated the following: 1/6/12-Regular diet. A nutrition care plan for Resident #96 indicated the following: Problem-The resident is nutritionally at risk related to a diagnosis of Dementia. She has a poor appetite and weight loss. Goal-To maintain weight with no unexplained significant weight loss through the next review. Approaches-1.) Honor food preference. 2.) Monitor food and fluid intake. 3.) Monitor weight. 4.) Nutrition at risk as needed. 5.) Notify MD and family of significant weight changes. 6.)Provide diet per MD order. 7.) Review labs as available. Resident #96 was observed seated at the dining table with her peers on 2/8/12 at 12:20 P.M. She was served a mechanical soft diet which included noodles, peas, bread and butter, cake, and ground pork chop. Staff had to start Resident #96 eating by example and encouragement. Until staff began assisting and encouraging Resident #96, she sat and looked at her food and the food around her on other residents' plates. After staff		review of contents of the CNA assignment sheet, utilizing BIR and documenting on resident refusals, and physician and family notification of residents with condition change and documentation. Physician will be notified of residents with change in condition for orders. All resident physician orders have been reviewed per nursing management. Admit/Re-admit oders will be verified by 2 licensed nurses with IDT review. Speech therapy will be notified to evaluate residents with down grade in diet to ensure approriateness. Licensed nurse will uitlize a dietary communication form when obtaining order to change a residents diet. Charge nurses will give verbal report on residents identified on hot charting/changes in condition to assigned CNA and follow up with completion / check CNA has appropriate CNA assignment sheet.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on obtaining physician orders and verification of orders, speech therapy evaluation with a adiet down grade, dietary communication form, utilization of CNA assignment sheet and review of contents of the CNA assignment sheet, utilizing BIR	

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	encouraged and prompted Resident #96 to eat, she began eating and drinking independently. An interview with RN #7 on 2/9/12 at 1:53 P.M., indicated Resident #96 did not know to put the food in her mouth but would usually eat good with encouragement and prompts. RN #7 indicated Resident #96 had to be fed at times, when encouragement and prompts didn't work. An interdisciplinary team note documented by LPN # 8 on 2/10/12 at 9:12 A.M., indicated the following: "IDT met to review resident's weight in nutrition at risk, due to weight loss. No problem chewing or swallowing. Receives a regular diet with 2 pieces of bread with each meal to enable resident to make sandwiches out of food. Resident consumes bites to 75% of meals with much encouragement from staff". Resident #96's tray card indicated the following: Mechanical soft diet. 2 Pieces of bread. Single serve dishes. An interview with the Dietary Manager on 2/13/12 at 2:39 P.M., indicated she reviewed the diet recommendations and orders for Resident #96 and could not find a physicians order for a		and documenting on reisdents refusals, and physician and family notification of residents with condition change and documentation. Physician will be notified of residents with change in condition for orders. Admit/Re-admit orders will be verified by 2 licensed nurses with IDT review. Speech therapy will be notified to evaluate residents with down grade in diet to ensure appropriateness. Licensed nurse will complete a dietary communication form when obtaining new diet order for daily review and verification of order in place by DNS/designee. Charge nurses will give verbal report on residents identified on hot charting/changes in condition to assigned CNA and follow up with completion / check CNA has appropriate CNA assignment sheet.4) How the corrective action(s) will be monitored to ensure the deficient practice will nor reocur: The CQI audit tool for Change in Condition as well as 24 Hour Condition Report will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 months and for 3 quarters thereafter for any resident who has a change in condition. Finding from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what date the systemic changes will be complete: The corrective actions will be completed on or	

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	mechanical soft diet. The Dietary Manager indicated "probably what happened was me and a nurse discussed her diet and decided to try a mechanical soft to see if her intakes would improve, but we did not follow through with the order". The Dietary Manager indicated there was no documentation regarding the mechanical soft diet change for Resident #96 or why. The Dietary Manager indicated she did not know when Resident #96's diet was changed from regular to mechanical soft. An interview with the Dietary Manager on 2/14/12 at 9:37 A.M., indicated Resident #96 did not do well with meats on a regular diet, so she, and RN #7 decided to try the mechanical soft diet as a nursing measure, to see if Resident #96's intakes would improve. The Dietary Manager indicated she did not receive a physicians order for the diet change, and she did not discuss the diet change with the Registered Dietician. 2.) During interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., indicated the resident had been sent to the hospital and was treated for mouth sores and the resident's mouth had improved. The family members		before 3/15/2012	

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	indicated when the resident returned to the facility, the resident's mouth started getting bad again. The family member indicated they insisted the facility treat the resident's mouth sores. Family member #1 indicated they took out the resident's dentures and cleaned them today. During observation and interview on 2-13-12 at 9:06 a.m., Resident #20 was lying in bed with her dentures in her mouth. The resident's dentures appeared dirty and had a film on them. The resident's tongue was bright red and swollen. The resident indicated she had thrush and was unsure how long she had it. The resident indicated the facility gives her something to swish in her mouth and it helps. The resident indicated her mouth was still sore and she also had sores on her gums. Resident #20 indicated the facility was supposed to take the dentures out and soak them over night. During observation of the resident's denture cup, it was dated 1-22-12 and marked with the resident's name. The denture cup was completely dry. Resident #20 indicated she had been sleeping in her dentures since Family member #1 cleaned them on Thursday. This indicated the dentures had not been taken out of her mouth for 3 days.			

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	Review of Resident #20's Medication Administration Record (MAR) on 2-13-12 at 9:39 a.m., indicated the resident was to have her dentures out of her mouth unless she was eating. Interview with CNA #2 on 2-13-12 at 9:40 a.m., indicated the information about Resident #20's dentures not being in her mouth should have been on the CNA assignment sheet. Review of the CNA assignment sheet with CNA #2 did not indicate any information about the resident not having her dentures in except when she was eating. CNA #2 indicated she did not know how information like that was supposed to be communicated to the CNAs. CNA #2 indicated she did not know Resident #20 had false teeth. Interview with LPN #5 on 2-13-12 at 9:53 a.m., indicated the reason Resident #20 was not have dentures in except while eating was because the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to have her dentures out of her mouth.			

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Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included,but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar).

The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15- cognitively intact and personal hygiene (including brushing teeth) was extensive assistance of one person.

The local hospital discharge note for Resident #20 dated 1-10-12, indicated the resident complained of sores in her mouth, this was most likely secondary to the steroids she inhales. She was started on Mary's magic mouthwash (treatment for oral lesions and oral pain) and that seemed to help her. The resident was being discharged back to the facility with a prescription for this.

The discharge medication list from

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	the local hospital for Resident #20 dated 1-10-12, indicated the resident was ordered Mary's magic mouthwash 5 milliliters every six hours, and the last dose was given on 1-10-12 at 10:00 a.m. The facility's physician orders for Resident #20 dated 1-10-12, indicated no order for Mary's magic mouthwash. The orders were signed by LPN #9. The physician orders were not signed by the physician. The progress note for Resident #20 dated 1-10-12 at 3:45 p.m., indicated Resident #20 had returned from the hospital. The doctor orders were noted from hospital and faxed to the pharmacy and the doctor. The progress note for Resident #20 dated 1-25-12 at 6:39 p.m., indicated the resident's mouth was sore again. This was reported to the doctor without getting an answer back about what to do. The progress note for Resident #20 dated 1-25-12 at 7:11 p.m., indicated a call was placed to resident's family. The resident's family requested the resident to have Mary's magic mouthwash. The family member was notified that the physician was out of			

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	the office and there would be a follow up in the morning with the office. The fax sent to the physician for Resident #20 dated 1-26-12 at 7:50 a.m., indicated the resident complained of a sore throat and mouth. The resident's family was requesting Mary's magic mouthwash. May we have an order? The physician response was, ok one teaspoon four times a day for 10 days. The progress note for Resident #20 dated, 1-26-12 at 6:36 p.m., indicated the received an order for Mary's magic mouthwash 1 tsp four times a day for 10 days. Review of the MAR for Resident #20 dated 1-10-12 through 1-31-12, indicated the resident received her first dose of Mary's magic mouthwash 5 milliliters on 1-27-12 at 6:00 a.m. This indicated the resident went 17 days without treatment for oral sores from the day of discharge from the local hospital on 1-10-12. The physician order for Resident #20 dated 2-9-12 at 12:00 p.m. indicated the resident was only to have dentures in when eating until mouth heals.			

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	Interview with RN #10 on 2-14-12 at 10:16 a.m., indicated the procedure for when a resident returned from the hospital was the discharge medication orders were usually faxed to the physician or the physician was called with the list of discharge medications. RN #10 indicated the physician had not signed the physician orders for Resident #20's medication on 1-10-12. The physician services policy provided by the Administrator on 2-14-12 at 1:55 p.m., indicated "A qualified physician supervises the healthcare of every resident." The physician reviews the resident's program of care including medications and treatments. The physician signs and dates all orders. 3.1-35(g)(2)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on observation, record review and interview, the facility failed to treat unrelieved pain, causing inability to sleep and carry out activities of daily living, for 1 of 3 residents reviewed for pain of 4 who met the criteria for pain recognition and management. (Resident #6) B. Based on observation, record review and interview, the facility failed to treat a resident's mouth sores, causing her pain and inability to eat, for 1 of 3 residents reviewed for nutrition of 8 who met the criteria for nutrition. (Resident #20) Findings include: A.) The record of Resident #6 was reviewed on 2/9/12 at 1:45 p.m. Resident #6's diagnoses included but were not limited to anxiety, stroke with left side weakness, osteoporosis, right forearm lesions, chronic left shoulder and hip pain, arthritis,	F0309	F-309 Provide Care/Services For Highest Well Being1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #6 has been evaluated by physician and therapy, pain assessment completed, pain medication review and care plan review, no new pain medication orders noted. Resident #20 has been evaluated by physician, pain assessment completed, medication review and care plan review.2) How other residents having the potential to be affected by the same deficient practice will be identifed and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by the DNS/designee (3/6/12) on pain management policy, pain assessment, non-medication interventions for pain, and change in condition, and review SBAR uitlization for new or worsening conditions with physician / family notification. Residents pain assessments will	03/15/2012

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	depression and rhabdomyolysis (degeneration of skeletal muscle tissue, as from traumatic injury, excessive exertion, or stroke). Resident #6's most recent MDS (Minimum Data Set), assessment, dated 12/7/12 indicated the following: "- BIMS (brief interview for mental status), 15, a score of 13 to 15 indicates cognitively intact - pain, on scheduled pain medication, yes - received PRN (as needed) pain medication, yes - interventions other than medication, yes - pain presence, yes - how often experiencing pain, frequently - verbal description of pain scale, moderate" Resident #6's care plan dated 12/15/11, indicated "Problem, resident has pain related to decreased mobility and osteoporosis and a history of rhabdomyolysis. Goal, will have relief of pain within 30 to 60 minutes of intervention. Approach, administer medications as ordered, non medication interventions such as rest, quiet environment, therapies as ordered and notify physician if pain is unrelieved and/or		be reviewed by DNS/ designee for completion and assessments up dated if indicated. Licensed nurse will fill out a Situation Background Assessment Recommendation (SBAR) and notify physician of a new or worsening condition, add resident to 24 hour condition report for on going monitoring. . Residents pain assessments reviewed no less than quarterly by IDT. All residents who experience change in pain will have physician notification. All residents will be assessed weekly for mouth sores and physician will be notified if indicated per assessment.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by the DNS/designee (3/6/12) on pain management policy, pain assessment, non-medication interventions for pain, and changes in condition, and review SBAR utilization for new or worsening conditions with physician / family notification. Residents pain assessments /oral assessments will be reviewed for completion by DNS/designee and assessments up dated if indicated. Licensed nurse will fill out a SBAR and notify physician of a new or worsening condition, add resident to 24 hour condition report. SBAR will be reviewed daily by IDT and 24 hour report monitoring per IDT to identify and	

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	worsening." Resident #6's most recent "Pain Assessment (interviewable resident)", dated, 11/29/11, indicated the following "- is the resident currently on routine pain medications, yes - are you currently experiencing pain, yes - have you had pain or hurting at any time in the last 5 days, yes - over the past 5 days, has pain made it hard for you to sleep at night, yes - over the past 5 days, have you limited your day-to-day activities because of pain, yes - what is the location of your pain, left shoulder - please rate the intensity of your worst pain over the last 5 days, (this question not marked) - how much of the time have you experienced pain or hurting over the last 5 days, frequently - type of pain, aching - what causes your pain to increase, movement." Resident #6's physician order dated 3/6/11, indicated "Tylenol 500 mg (milligrams), by mouth, twice a day, and Ibuprofen 400 mg, by mouth, take 1 tablet PRN every 6 hours."		add residents to 24 hour condition report . 24 hour report monitoring per IDT for physician and family notification. Therapy screen for any resident with increased or unresolved pain.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The CQI audit too for Change in Condtion, Pain Management, and 24 Hour Condition Report will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 months and for 3 quarters thereafter for any resident who has pain / chnage in condition. Finding from CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%5) By what date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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	Resident #6's physician's "History and Physical Examination" dated 3/5/11 indicated "Past History" included, but was limited to, "addiction to pain medication." Resident #6's "Nurse's Medication" with documentation of PRN medications indicated "2/14/12, medication, Ibuprofen, reason, general body ache, results/response, (left blank)." Interview with Resident #6 on 2/9/12 at 1:45 p.m., indicated she was having left arm and shoulder pain. Resident #6 indicated she receives Ibuprofen for her left arm pain and the Tylenol helps very little. Resident #6 also indicated she receives Tylenol everyday and the Tylenol does not help her pain at all. She indicated she has told the nurses because it keeps her awake at night, it hurts too bad for her to try to hold onto the walker to walk and she just does not feel like doing anything. On 2/14/12 at 9:45 a.m., Resident #6 was observed in bed. Resident #6 was pointing with her right hand to her left arm and hand and stated "my left arm hurts so bad and it kept me awake most of the night last night."			

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	During interview with 2/14/12 at 9:50 a.m., indicated she was having a pain in her left arm and hand right now and she indicated on a pain scale of 0-10 it her pain was an 8. She stated "the Ibuprofen does not help, I had it this morning and it just didn't help that much if any. I try not to think about the pain but it is hard to not think about it when it is hurting. I did not sleep much last night because of the pain." During interview on 2/14/12 at 10:40 a.m., the Assistant Director of Nursing (ADON) indicated Resident #6's pain has not been reported to the physician that she is aware of, but the pain medication had not been changed because Resident #6 had a history of addiction to pain medication. During interview on 2/12/12 at 10:58 a.m., staff Physical Therapist #9 indicated Resident #6 is receiving physical therapy at this time and does experience pain in her left arm. Staff Physical Therapist #9 also indicated a splint had been ordered for Resident #6 to help with her mobility and pain. A document titled "Pain Management" dated 3/10, provided by the Administrator on 2/14/12 at 1:55 p.m.,			

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	and indicated by the Administrator to be the most current policy, indicated "Policy, it is the policy of American Senior Communities to provide, mental, and psychosocial well being, including pain management. It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keeping the resident as comfortable and pain free as possible. Procedure, residents are assessed for pain upon admission, quarterly, and with a significant change in the resident's condition and/or new onset of pain. The following guidelines will be used when assessing pain, using the specific pain assessment. Interviewable resident, the pain management program will be determined based upon the resident's verbal response to the questions on the pain assessment/interviewable resident. Pain medications will be prescribed and given based upon the intensity of the pain as follows: mild, moderate, severe, very severe, horrible. B.) During interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., the family indicated they had talked with the facility numerous times about			

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	the resident losing weight and having mouth sores. The family members indicated the resident had been sent to the hospital and was treated for the mouth sores, and the resident's mouth had improved. The family members indicated when the resident returned to the facility, the resident's mouth started getting bad again. The family member indicated they insisted the facility treat the resident's mouth sores. The family members indicated the resident had not been able to eat due to the mouth sores. The family members indicated the resident was little and weak now because she had been unable to eat. The family members indicated the facility does not give the resident assistance with oral hygiene and they felt the poor oral hygiene also contributed to the resident's sore mouth. Family member #1 indicated the resident's dentures were "a mess" when they came to the facility today. Family member #1 indicated they cleaned the dentures for the resident. During observation and interview on 2-13-12 at 9:06 a.m., Resident #20 was lying in bed with her dentures in her mouth. The resident's dentures appeared dirty and had a film on them. The resident's tongue was bright red and swollen. The resident			

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	155160	A. BUILDING 00 B. WING	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

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	indicated she had thrush and was unsure how long she had it. The resident indicated she had lost a lot of weight because her mouth had been sore and she was unable to eat. The resident indicated she did not feel like there were any other contributing factors to her weight loss; her mouth was too sore to eat. The resident indicated the facility gives her something to swish in her mouth, and it helps. The resident indicated her mouth was still sore and she also had sores on her gums. The resident indicated she had sour kraut the other day, and it was the first food she could really taste since having thrush. The resident indicated ever since she had thrush, nothing tastes right. The resident indicated food does not have any taste. The resident indicated the last time the facility weighed her, she weighed 108 pounds. The resident indicated she usually weighed a lot more than that. The resident indicated she hoped she did not lose any more weight. Resident #20 indicated her dentures had not been cleaned since Family member #1 cleaned them last week. Resident #20 indicated the facility was supposed to take the dentures out and soak them over night. During observation of the resident's denture cup, it was dated 1-22-12 and marked with the			

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	resident's name. The denture cup was completely dry. Resident #20 indicated she had been sleeping in her dentures since Family member #1 cleaned them on Thursday. This indicated the resident had not had her dentures cleaned or taken out of her mouth for three days. During observation, CNA #2 came into Resident #20's bedroom and asked if the resident was ready to get up, the resident indicated no she was not ready to get up yet. Interview with CNA #2 on 2-13-12 at 9:25 a.m., indicated she cleans resident's dentures daily. CNA #2 indicated Resident #20 had not ate breakfast today. CNA #2 indicated she did not know when resident's dentures should be soaked; she thought evening shift should take them out at night and soak them. CNA #2 indicated Resident #20's dentures had not been cleaned today. CNA #2 indicated a lot of residents already have their dentures in when she starts work in the morning. CNA #2 indicated some residents sleep with their dentures in. CNA #2 indicated the facility did not have tablets to soak the residents' dentures in; the residents' families had to provide the cleaning tablets for the residents. CNA #2 indicated denture			

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	cups should be changed every three days. During observation with CNA #2 at this time, there were three boxes of cleaning antibacterial with baking soda effervescent single tablet boxes with 40 tablets per box in the storage room. CNA #2 stated " I guess we do have them." Review of Resident #20's Medication Administration Record (MAR) on 2-13-12 at 9:39 a.m., indicated the resident was to have her dentures out of her mouth unless she was eating. Interview with CNA #2 on 2-13-12 at 9:40 a.m., indicated the information about Resident #20's dentures not being in her mouth should have been on the CNA assignment sheet. Review of the CNA assignment sheet with CNA #2 did not indicate any information about the resident not having her dentures in except when she was eating. CNA #2 indicated she did not know how information like that was supposed to be communicated to the CNAs. CNA #2 indicated she did not know Resident #20 had false teeth. Interview with LPN #5 on 2-13-12 at 9:53 a.m., indicated the reason Resident #20 was not have dentures in except while eating was because			

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	the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to have her dentures out of her mouth. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included,but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15- cognitively intact and personal hygiene (including brushing teeth) was extensive assistance of one person. The local hospital discharge note for Resident #20 dated 1-10-12, indicated the resident complained of sores in her mouth, this was most likely secondary to the steroids she			

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	inhales. She was started on Mary's magic mouthwash (treatment for oral lesions and oral pain) and that seemed to help her. The resident was being discharged back to the facility with a prescription for this. The discharge medication list from the local hospital for Resident #20 dated 1-10-12, indicated the resident was ordered Mary's magic mouthwash 5 milliliters every six hours, and the last dose was given on 1-10-12 at 10:00 a.m. The facility's physician orders for Resident #20 dated 1-10-12, indicated no order for Mary's magic mouthwash. The orders were signed by LPN #9. The physician orders were not signed by the physician. The progress note for Resident #20 dated 1-10-12 at 3:45 p.m., indicated Resident #20 had returned from the hospital. The doctor orders were noted from hospital and faxed to the pharmacy and the doctor. The progress note for Resident #20 dated 1-25-12 at 6:39 p.m., indicated the resident's mouth was sore again. This was reported to the doctor without getting an answer back about what to do.			

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The progress note for Resident #20 dated 1-25-12 at 7:11 p.m., indicated a call was placed to resident's family. The resident's family requested the resident to have Mary's magic mouthwash. The family member was notified that the physician was out of the office and there would be a follow up in the morning with the office.

The fax sent to the physician for Resident #20 dated 1-26-12 at 7:50 a.m., indicated the resident complained of a sore throat and mouth. The resident's family was requesting Mary's magic mouthwash. May we have an order? The physician response was, ok one teaspoon four times a day for 10 days.

The progress note for Resident #20 dated, 1-26-12 at 6:36 p.m., indicated the received an order for Mary's magic mouthwash 1 tsp four times a day for 10 days.

Review of the MAR for Resident #20 dated 1-10-12 through 1-31-12, indicated the resident received her first dose of Mary's magic mouthwash 5 milliliters on 1-27-12 at 6:00 a.m. This indicated the resident went 17 days without treatment for oral sores from the day of discharge from the

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	local hospital on 1-10-12. The weights for Resident #20 indicated on 10-1-11, the resident weighed 122 pounds, and on 2-13-12 the resident weighed 107 pounds. The ER (Emergency Room) record for Resident #20 dated 2-8-12, indicated the resident had a syncope episode shortly after choking on a large pill. The resident stated she felt very weak. The resident had weight loss in last several months and was thin. The resident had a decrease in appetite since severe episode of thrush. The physician order for Resident #20 dated 2-9-12 at 12:00 p.m. indicated the resident was only to have dentures in when eating until mouth heals. Interview with RN #10 on 2-14-12 at 10:16 a.m., indicated the procedure for when a resident returned from the hospital, was the discharge medication orders were usually faxed to the physician or the physician was called with the list of discharge medications. RN #10 indicated the physician had not signed the physician orders for Resident #20's medication on 1-10-12.			

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	3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to assist a resident who needed assistance with activities of daily living with oral care for 1 of 2 residents reviewed for activities of daily living of 2 who met the criteria for activities of daily living (Resident #20). Finding includes: During interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., the family indicated they had talked with the facility numerous times about the resident losing weight and having mouth sores. The family members indicated the resident had been sent to the hospital and was treated for the mouth sores, and the resident's mouth had improved. The family members indicated when the resident returned to the facility, the resident's mouth started getting bad again. The family member indicated they insisted the facility treat the resident's mouth sores. The family members indicated the resident had not been able to eat	F0312	F-312 ADL Care Provided For Dependent Residents1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 dentures removed and cleaned and removed after meals to facilitate mouth healing.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by DNS/designee (3/6/12) on resident hyigene , oral care, denture care including cleaning and storing of dentures, oral assessment, utilization of CNA assignment sheet and assignment sheet contents, location of hyigene supplies, utilizing Behavior Incident Review (BIR) with residents refusals of care, and documentation / 24 hour condition report. Licensed nurse will complete weekly oral / skin assessment. Charge nurse will give verbal report on residents identified on 24 hour condition report / change in condtion to assigned CNA and follow up	03/15/2012

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	due to the mouth sores. The family members indicated the resident was little and weak now because she had been unable to eat. The family members indicated the facility does not give the resident assistance with oral hygiene and they felt the poor oral hygiene also contributed to the resident's sore mouth. Family member #1 indicated the resident's dentures were "a mess" when they came to the facility today. Family member #1 indicated they cleaned the dentures for the resident. During observation and interview on 2-13-12 at 9:06 a.m., Resident #20 was lying in bed with her dentures in her mouth. The resident's dentures appeared dirty and had a film on them. The resident's tongue was bright red and swollen. The resident indicated she had thrush and was unsure how long she had it. Resident #20 indicated her dentures had not been cleaned since Family member #1 cleaned them last week. Resident #20 indicated the facility was supposed to take the dentures out and soak them over night. During observation of the resident's denture cup, it was dated 1-22-12 and marked with the resident's name. The denture cup was completely dry. Resident #20 indicated she had been		assignment completion. Charge nurse will check CNA has appropraite CNA assignment sheet. Staff Developement Coordinator will orient all new hired nursing staff to location of supplies. CNA binder in place with denture cup replacing schedule. CNA assignment sheet updated 5 days week as new orders / interventions occur. All residents will have oral assesssment completed weekly, if physician notification if indicated.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on resident hyigene, oral care, denture care including cleaning and storing of dentures, oral assessment, utilization of CNA assignment sheet and assignment sheet contents, location of hyigene supplies, utilizing BIR with residents refusals of care, and documentation / 24 hour condition report. Licensed nurse will complete weekly oral/skin assessment, IDT to audit weekly for completion. Charge nurse will give verbal report on residents identified on on 24 hour condition report/ change in condition to assigned CNA and follow up on assignment completion. Charge nurse will check CNA has appropriate CNA assignment	

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	sleeping in her dentures since Family member #1 cleaned them on Thursday. This indicated the resident had not had her dentures cleaned or taken out of her mouth for three days. During observation, CNA #2 came into Resident #20's bedroom and asked if the resident was ready to get up, the resident indicated no she was not ready to get up yet. Interview with CNA #2 on 2-13-12 at 9:25 a.m., indicated she cleans resident's dentures daily. CNA #2 indicated Resident #20 had not ate breakfast today. CNA #2 indicated she did not know when resident's dentures should be soaked; she thought evening shift should take them out at night and soak them. CNA #2 indicated Resident #20's dentures had not been cleaned today. CNA #2 indicated a lot of residents already have their dentures in when she starts work in the morning. CNA #2 indicated some residents sleep with their dentures in. CNA #2 indicated the facility did not have tablets to soak the residents' dentures in; the residents' families had to provide the cleaning tablets for the residents. CNA #2 indicated denture cups should be changed every three days. During observation with CNA #2 at this time, there were three boxes of		sheet. Staff development coordinator (SDC) will orient all new hired nursing staff to location of supplies. CNA binder in place with denture cup replacing schedule will be reviewed weekly by DNS/designee CNA assignment sheet updated 5 days week as new orders / interventions occur per ADNS, Charge nurse will make changes and up dates on weekend. BIR review daily per IDT with care plans up dated as indicated. Daily rounds every shift, per charge nurse to ensure CNA assignment sheets are followed.4) How the corrective action(s) will be monitored to ensure the deficient practice wi ll not recur: Skills validation for oral care/ dentures will be completed on all CNAs and any new hire CNAS. per SDC Weekly skin/oral assessment audit weekly for completion per DNS/ADNS The CQI audit tool for Accomodation of Needs will be utilized daily x 4 weeks, bi-weekly x 2months, and monthly x 3 months and for 3 quarters thereafter. Findings form the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what date the systemic changes will complete: The corrective actions will be completed on or before 3/15/12.	

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	cleaning antibacterial with baking soda effervescent single tablet boxes with 40 tablets per box in the storage room. CNA #2 stated " I guess we do have them." Review of Resident #20's Medication Administration Record (MAR) on 2-13-12 at 9:39 a.m., indicated the resident was to have her dentures out of her mouth unless she was eating. Interview with CNA #2 on 2-13-12 at 9:40 a.m., indicated the information about Resident #20's dentures not being in her mouth should have been on the CNA assignment sheet. Review of the CNA assignment sheet with CNA #2 did not indicate any information about the resident not having her dentures in except when she was eating. CNA #2 indicated she did not know how information like that was supposed to be communicated to the CNAs. CNA #2 indicated she did not know Resident #20 had false teeth. Interview with LPN #5 on 2-13-12 at 9:53 a.m., indicated the reason Resident #20 was not have dentures in except while eating was because the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the			

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	resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to have her dentures out of her mouth. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included,but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15- cognitively intact and personal hygiene (including brushing teeth) was extensive assistance of one person. 3.1-38(a)(3)(C)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to provide a resident who had skin issues and a history of Urinary Tract Infections (UTI) with timely incontinence care and proper incontinence care for 1 of 1 resident sampled for incontinence care in a stage 2 sample of 15 (Resident #20). Finding include: 1.) Interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., indicated the resident's perineal area was always red and sore. The family members indicated the resident complained a lot that her perineal area hurt her and burned. The family members indicated when they visit the resident, they find the resident wet a lot. The family members	F0315	F-315 No Cathether, Prevent UTI, Restore Bladder1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 will receive incontinent care every 2 hours per policy, with appropriate pericare, and treatment order in place.2) How other residents having the potiental to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by DNS/designee (3/6/12) on perineal care policy, check/changing an incontinent resident, skin care / preventative treatments, weekly skin assessments, review of cleasning products and usage guidelines, and preventative barriers. Pericare validations will be completed on all CNAs by	03/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 00 B. WING	02/14/2012

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STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

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	indicated the resident was unable to take herself to the bathroom. Family member #2 indicated to please look at the resident's bottom because it was so red and sore. During observation and interview with Resident #20 on 2-13-12 at 9:06 a.m., the resident smelled strongly of urine. The resident indicated she knew when she was wet from incontinence sometimes, but not always. The resident indicated she did not know when she had to use the bathroom. The resident indicated she was always sore in her perineal area. The resident indicated sometimes the CNAs put a salve on me and it helps; "it feels good." During observation and interview on 2-13-12 at 10:10 A.M., CNA #6 and CNA #3 were providing incontinence care to Resident #20. Resident #20 indicated she did not wear depends to bed because she was so sore in her perineal area and the staff said it would be better if she left them off while she was in bed. The resident's sheet and night gown and two of three pads on the resident's bed were soaked with urine. When queried when the last time the resident was checked for incontinence, CNA #6 indicated approximately around eight.		DNS/SDC by 3/15/12. Skin assessments completed weekly identifying residents at risk and in need of preventative treatment. CNAs to notify nurse of resident refusals of incontinent care or residents with noted skin issues. Refer residents to toileting program when appropriate. CNA will apply preventative barrier to all incontinent residents.3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on perineal care policy, check/changing an incontinent resident, skin care / preventative treatments, weekly skin assessments, review of cleansing products and usage guidelines. Pericare validations will be completed on all CNAs by DNS/SDC by 3/15/12. Skin assessments completed weekly identifying residents at risk and in need of prevtative treatment per licensed nurse. CNAs to notify nurse of resident refusals of incontient care or residents with noted skin issues. Refer residents to toileting program when appropriate. Charge nurse to do daily rounds to ensure appropirate pericare completed.4) How the corrective action(s) will be monitored to ensure the deficient practice will	

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	Resident #20 indicated she had not been changed yet today; the staff checked and changed her last night. CNA #6 indicated the resident was not wet this morning. CNA #6 indicated they normally check residents for incontinence every two hours. The resident's perineal area was observed to be pink and red. CNA #6 indicated "yes the resident's bottom is normally that red." CNA #6 washed the resident's perineal area with soap and dried the resident. CNA #6 began dressing the resident without rinsing the soap off. CNA #6 indicated they did not rinse the soap off the resident because the resident told us we do not have to; it was a no rinse soap. Observation of the bottle of soap indicated to rinse soap off. CNA #6 went and got more wash cloths and rinsed the resident's buttocks off and did not rinse the genital area. Neither CNA dried the resident off after the soap was rinsed off. CNA #6 and CNA #3 then transferred Resident #20 into her wheelchair. The resident's wheelchair did not have a pressure reducing cushion in it. When queried if any type of moisture barrier was supposed to be used, CNA #3 indicated Resident #20 did not have any type of barrier cream that was supposed to be applied after		not recur: Pericare validations completed on all CNAs by DNS/SDC by 3/15/12 and quarterly thereafter. Skin assessments completed weekly per licensed nurse and audited per IDT weekly for completeion. The CQI audit tool for Accomodation of Needs will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthy x 3 months for 3 quarters thereafter. Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%5) By what date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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	incontinence care. Interview with the Assistant Director Of Nursing (ADON) on 2-12-12 at 2:38 p.m. indicated Resident #20's perineal area was not always red. The ADON indicated it got red sometimes, and the resident always has had problems with excoriation. The ADON indicated CNAs should let the nurse know if a resident's perineal area was always being red and then the nurse would tell her about it. The ADON indicated she was going to have therapy look at getting the resident a cushion for her wheelchair. The ADON indicated therapy always evaluated residents for pressure cushion devices in the chair, and nursing did the evaluations for mattresses. The ADON indicated CNAs could get barrier cream out of the supply room. The ADON indicated CNAs could use barrier cream with any residents. The ADON indicated she would put it on the CNA assignments for Resident #20 to have barrier cream. Interview with the ADON on 2-14-12 at 9:40 a.m., indicated she got a physician order for Resident #20's treatment to be Calmoseptine every shift for 7 days. The ADON indicated she looked at Resident #20's perineal			

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	area today. The ADON indicated the resident's peri area and inner buttocks were pink with no open areas. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15 - cognitively intact, bed mobility- extensive assistance of one person, transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, urinary and bowel continence- frequently incontinent. The care plan for Resident #20 dated 6-28-11, indicated the resident was incontinent due to decreased mobility and at risk for recurrent UTI's. The interventions included, but were not limited to, assist with incontinent care			

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	as needed. The care plan for Resident #20 dated 6-28-11, indicated the resident had potential for skin breakdown related to decreased mobility, incontinence, anemia, and history of skin issues. The interventions included, but were not limited to, peri care after each incontinent episode. The care plan for Resident #20 dated 8-1-11, indicated the resident required a toileting program to prevent decline in continence. The interventions included, but were not limited to, incontinent care as needed using peri wash and moisture barrier. The local hospital admission note dated 1-4-12, indicated the resident was admitted to the hospital for probable right lower lobe pneumonia and possible urinary tract infection. The laboratory urine culture report from the local hospital for Resident #20 dated 1-5-12, indicated the resident had an urinary tract infection. The perineal care policy, provided by the Administrator on 2-13-12 at 3:06 p.m., indicated after washing a resident, change the water basin and rinse the area thoroughly. Gently pat			

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	dry the area. 3.1-41(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to give a resident medication in a manner to prevent choking, resulting in the resident being transferred to the Emergency Room (ER) for evaluation for 1 of 3 residents reviewed for accidents, of 8 residents who met the criteria for accidents (Resident #20). Finding include: Interview with Family #1 and Family #2 of Resident #20 on 2-9-12 at 2:09 p.m., indicated the nurse did not put the resident's potassium in applesauce on 2-8-12 and the resident got choked and was sent to the Emergency Room. The family members indicated the resident's medication was always given to her in applesauce. Interview Resident #20 on 2-13-12 at 9:06 a.m. indicated the staff usually put medication in applesauce. Resident #20 indicated the staff did not that day. Resident #20 indicated	F0323	F-323 Free Of Accident Hazards/Supervision/Devices1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 medication has been changed to liquid formulary to faciliate swallowing and has a may crush medication order in place.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrctive action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by DNS/designee (3/6/12) on notifying physician of a resident choking, obtain orders to change medication to liquid if appropriate, family notification, place resident on 24 hour coition report for choking, obtain a may crush order for medications, speech therapy evaluation for follow up assessment. Physician will be notified if choking is identified and orders for liquid medication if available and appropriate. Resident choking will be identified on 24 hour condition report for 24 hour	03/15/2012

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	she was on the way to the dining room and the nurse stopped her and gave her medicine without applesauce and "I got choked." The resident stated "they always put in applesauce; they must have been in a hurry that day." Interview with LPN #1 on 2-13-12 at 9:37 a.m., indicated she knew which residents required their medication in applesauce from over the years working with them. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The progress note for Resident #20 dated 2-8-12 at 12:54 p.m., indicated at approximately 12 p.m. the resident choked on her potassium pill. Approximately 25 minutes later during lunch, CNA reported the resident became lethargic and unresponsive. The resident was found sitting in wheelchair, able to answer questions,		continued follow up and documentation. Speech therapy will be notified to evaluate residents experiencing choking or difficulty swallowing. All residents will have a may crush medication order if appropriate per pharmacy.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on notifying physician of a resident choking, obtain orders to change medication to liquid if appropriate, family notification, place resident on 24 hour condition report for choking, obtain a may crush order for medications, speech therapy evaluation for follow up assessment. Physician will be notified if choking is identifed and orders for liquid medication if available and appropriate. Orders will be reviewed daily by IDT. Resident choking will be identified on24 hour condition report for 24 hour continued follow up and documentation. 24 hour condition report will be reviewed daily by IDT to recognize residents on 24 hour condition report. Speech therapy will be notified to evaluate residents experiencing choking or difficulty swallowing.4) How the corrective action(s) will be monitored to ensure the deficiecnt practice will not recur: The CQI audit tool for 24 Hour Condition Report as well as	

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	assessment and vitals completed. The resident indicated her stomach was upset and she did not feel well. The resident's family was called and they requested the resident be sent to the ER. The ER record for Resident #20 dated 2-8-12, indicated the resident had a syncope episode shortly after choking on a large pill. The resident states she feels very weak. The Speech Therapy plan of treatment for Resident #20 dated 2-12-12 at 5:17 p.m., indicated the reason for the referral was episode of choking with medication resulting in hospital stay. The caregiver education indicated for nursing to be educated on safety for consuming large pills. Nursing requested to dissolve potassium pill and place it in applesauce. Nurse stated that was already being done. Interview with LPN #1 on 2-13-12 at 11:15 a.m., indicated Resident #20 did not get her medication put in applesauce or crushed. LPN #1 indicated the resident took her medication whole. LPN #1 indicated as far as she knew Resident #20 had been taking them whole. LPN #1 indicated she had worked with		Change in Condition will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 months and for 3 quarters thereafter for any resident with change in condition. Finding from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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	Resident #20 for a long time and had never put her medicine in applesauce or crushed it. LPN #1 indicated the resident did not like her medication in applesauce. During interview with Resident #20 on 2-13-12 at 11:20 a.m. when queried if she minded her medication being put in applesauce, the resident stated "no I don't mind it being put in applesauce; it is easier for me to take." "Especially the big pill, it gets stuck in my throat, they usually do put it in applesauce especially the big pill." During interview with LPN #1 on 2-13-12 at 11:25 a.m., when explained that the resident indicated she did not mind medications in applesauce and especially the big pill, LPN #1 stated "It is news to me; she is probably talking about her potassium." During interview on 2-13-12 at 12:00 p.m. Speech Therapy (ST) #4 indicated Resident #20 got choked on the potassium pill. The ST indicated most nurses dissolve the pill for her and on the day the resident got choked, they did not. The ST indicated the potassium pill was a very large pill. The ST indicated she			

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	talked with the ADON this morning about getting the potassium put on Resident #20's Medication Administration Record (MAR) to have that pill dissolved. During interview with the ADON on 2-13-12 at 12:05 p.m., she indicated she was going to educate nurses about Resident #20's medication being dissolved today. The ADON indicated she was going to get a doctors order for it today and put it on MAR to ensure it was done. During observation and interview on 2-13-12 at 12:48 p.m., with LPN #1 indicated she had called the pharmacy and they said it was ok to break Resident #20's potassium pill in half. LPN #1 indicated she asked Resident #20 if she wanted her medication in applesauce, and the resident indicated she did. Resident #20's potassium pill was observed at this time and it was large and had a score line in the middle of it. LPN #1 broke Resident #20's potassium chloride in half and placed it in applesauce. During observation of Resident #20 taking her medication, the resident was having problems getting the medication swallowed. LPN #1 gave the resident more applesauce. Resident #20 was			

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	chewing on her pills and stated "taste terrible." LPN #1 asked the resident if she wanted her to get the potassium pill in liquid form, and the resident stated "yes that would be better." Interview with the Director Of Nursing (DON) on 2-13-12 at 1:40 p.m., indicated the facility had attempted to get Resident #20 liquid form of potassium and the resident had refused. When queried how was the facility ensuring Resident #20 received her medication safely, the DON indicated it was on the 24 hour report. Review of the 24 report indicated the following: Monitor and document any chewing or swallowing difficulty, SOB (shortness of breathe), wheezing." The documentation did not indicate any information about the resident choking on medication or the need to dissolve the resident's potassium in applesauce. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to treat and evaluate a resident with mouth sores causing the resident the inability to eat and failed to ensure the resident was able to get sufficient nutrition, for 1 of 3 residents reviewed for nutrition of 8 who met the criteria for nutrition (Resident #20). Finding include: 1.) During interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., the family indicated they had talked with the facility numerous times about the resident losing weight and having mouth sores. The family members indicated the resident had been sent to the hospital and was treated for the mouth sores, and the resident's mouth had improved. The family members indicated when the resident	F0325	F-325 Maintain Nutrition Status Unless Unavoidable1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 has an order for ensure plus two times daily and resident weight is reviewed weekly in NAR and has been reviewed by RD. Resident #20 has completed oral assessment and has new order to continue treatment and reasses.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nusring staff will be re-educated by DNS/designee (3/6/12) on physician notification of resident change in condtion , oral care, oral assessment, offering alternative meal. Physician will be notified of resident change in condition. Residents with weight changes of	03/15/2012

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

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	returned to the facility, the resident's mouth started getting bad again. The family member indicated they insisted the facility treat the resident's mouth sores. The family members indicated the resident had not been able to eat due to the mouth sores. The family members indicated the resident was little and weak now because she had been unable to eat. The family members indicated the facility does not give the resident assistance with oral hygiene and they felt the poor oral hygiene also contributed to the resident's sore mouth. Family member #1 indicated the resident's dentures were "a mess" when they came to the facility today. Family member #1 indicated they cleaned the dentures for the resident. During observation and interview on 2-13-12 at 9:06 a.m., Resident #20 was lying in bed with her dentures in her mouth. The resident's dentures appeared dirty and had a film on them. The resident's tongue was bright red and swollen. The resident indicated she had thrush and was unsure how long she had it. The resident indicated she had lost a lot of weight because her mouth had been sore and she was unable to eat. The resident indicated she did not feel like there were any other contributing		5% in 30 days and 10% in180 days will be reviewed weekly by IDT in NAR. RD to assess residents with weight changes / 5% in 30 days and 10% in 180 days. Licensed nurse will complete weekly oral assessment. Residents with change in condition will be added to24 hour condition report per licensed nurse .3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on physician notification of resident change in condition, oral care, oral assessment, offering alterntive meal. Physician will be notified of resident change in condition. IDT will review physician orders and completion of SBAR daily. Residents with weight changes will be reviewed weekly by IDT in NAR. Registered Dietician to assess residents with weight changes / 5% in 30 days and 10% in 180 days. Licensed nurse will complete weekly oral assessment, DNS/designee will audit weekly for completion. Residents with change in condition will be added to 24 hour condition report, IDT to review daily for completion.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The CQI audit tool for Change in Condition	

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	factors to her weight loss; her mouth was too sore to eat. The resident indicated the facility gives her something to swish in her mouth, and it helps. The resident indicated her mouth was still sore and she also had sores on her gums. The resident indicated she had sour kraut the other day, and it was the first food she could really taste since having thrush. The resident indicated ever since she had thrush, nothing tastes right. The resident indicated food does not have any taste. The resident indicated the last time the facility weighed her, she weighed 108 pounds. The resident indicated she usually weighed a lot more than that. The resident indicated she hoped she did not lose any more weight. Resident #20 indicated her dentures had not been cleaned since Family member #1 cleaned them last week. Resident #20 indicated the facility was supposed to take the dentures out and soak them over night. During observation of the resident's denture cup, it was dated 1-22-12 and marked with the resident's name. The denture cup was completely dry. Resident #20 indicated she had been sleeping in her dentures since Family member #1 cleaned them on Thursday. This indicated the resident had not had her dentures cleaned or taken out of her		as well as 24 Hour Condition Report will be utilized daily x 4 weeks, bi-weekly x 2 months, and monthly x 3 months, and for 3 quarters thereafter for any resident with cahnge in condition. Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.5) By what date the systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	

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	mouth for three days. During observation, CNA #2 came into Resident #20's bedroom and asked if the resident was ready to get up, the resident indicated no she was not ready to get up yet. Interview with CNA #2 on 2-13-12 at 9:25 a.m., indicated she cleans resident's dentures daily. CNA #2 indicated Resident #20 had not ate breakfast today. CNA #2 indicated she did not know when resident's dentures should be soaked; she thought evening shift should take them out at night and soak them. CNA #2 indicated Resident #20's dentures had not been cleaned today. CNA #2 indicated a lot of residents already have their dentures in when she starts work in the morning. CNA #2 indicated some residents sleep with their dentures in. CNA #2 indicated the facility did not have tablets to soak the residents' dentures in; the residents' families had to provide the cleaning tablets for the residents. CNA #2 indicated denture cups should be changed every three days. During observation with CNA #2 at this time, there were three boxes of cleaning antibacterial with baking soda effervescent single tablet boxes with 40 tablets per box in the storage room. CNA #2 stated " I guess we do			

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	have them." Review of Resident #20's Medication Administration Record (MAR) on 2-13-12 at 9:39 a.m., indicated the resident was to have her dentures out of her mouth unless she was eating. Interview with CNA #2 on 2-13-12 at 9:40 a.m., indicated the information about Resident #20's dentures not being in her mouth should have been on the CNA assignment sheet. Review of the CNA assignment sheet with CNA #2 did not indicate any information about the resident not having her dentures in except when she was eating. CNA #2 indicated she did not know how information like that was supposed to be communicated to the CNAs. CNA #2 indicated she did not know Resident #20 had false teeth. Interview with LPN #5 on 2-13-12 at 9:53 a.m., indicated the reason Resident #20 was not have dentures in except while eating was because the resident's mouth got sore easy and she had thrush. LPN #5 indicated it was also to ensure the resident's dentures were cleaned. LPN #5 provided a copy of the CNA assignment sheet and there was no documentation for Resident #20 to			

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	have her dentures out of her mouth. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15- cognitively intact and personal hygiene (including brushing teeth) was extensive assistance of one person. The care plan for Resident #20 dated 1-17-12, indicated the resident was at risk for unintentional weight loss related to leaving 25% or greater of meals and diagnoses of COPD and depression. The interventions did not indicate any approaches or interventions related to the resident's sore mouth and gums. The local hospital discharge note for Resident #20 dated 1-10-12,			

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	indicated the resident complained of sores in her mouth, this was most likely secondary to the steroids she inhales. She was started on Mary's magic mouthwash (treatment for oral lesions and oral pain) and that seemed to help her. The resident was being discharged back to the facility with a prescription for this. The discharge medication list from the local hospital for Resident #20 dated 1-10-12, indicated the resident was ordered Mary's magic mouthwash 5 milliliters every six hours, and the last dose was given on 1-10-12 at 10:00 a.m. The facility's physician orders for Resident #20 dated 1-10-12, indicated no order for Mary's magic mouthwash. The orders were signed by LPN #9. The physician orders were not signed by the physician. The progress note for Resident #20 dated 1-10-12 at 3:45 p.m., indicated Resident #20 had returned from the hospital. The doctor orders were noted from hospital and faxed to the pharmacy and the doctor. The progress note for Resident #20 dated 1-25-12 at 6:39 p.m., indicated the resident's mouth was sore again.			

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	This was reported to the doctor without getting an answer back about what to do. The progress note for Resident #20 dated 1-25-12 at 7:11 p.m., indicated a call was placed to resident's family. The resident's family requested the resident to have Mary's magic mouthwash. The family member was notified that the physician was out of the office and there would be a follow up in the morning with the office. The fax sent to the physician for Resident #20 dated 1-26-12 at 7:50 a.m., indicated the resident complained of a sore throat and mouth. The resident's family was requesting Mary's magic mouthwash. May we have an order? The physician response was, ok one teaspoon four times a day for 10 days. The progress note for Resident #20 dated, 1-26-12 at 6:36 p.m., indicated the received an order for Mary's magic mouthwash 1 tsp four times a day for 10 days. Review of the MAR for Resident #20 dated 1-10-12 through 1-31-12, indicated the resident received her first dose of Mary's magic mouthwash 5 milliliters on 1-27-12 at 6:00 a.m.			

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	This indicated the resident went 17 days without treatment for oral sores from the day of discharge from the local hospital on 1-10-12. The weights for Resident #20 indicated on 10-1-11, the resident weighed 122 pounds, and on 2-13-12 the resident weighed 107 pounds. The ER (Emergency Room) record for Resident #20 dated 2-8-12, indicated the resident had a syncope episode shortly after choking on a large pill. The resident stated she felt very weak. The resident had weight loss in last several months and was thin. The resident had a decrease in appetite since severe episode of thrush. The physician order for Resident #20 dated 2-9-12 at 12:00 p.m. indicated the resident was only to have dentures in when eating until mouth heals. During observation and interview with Resident #20 on 2-13-12 at 12:48 p.m., the resident ate about 25 % of her lunch and indicated everything taste bland. During observation on 2-14-12 at 12:48 p.m., LPN #1 was passing			

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	medication to Resident #20. LPN #1 started to give the resident her Mary's magic mouthwash. Resident #20 indicated for the LPN to wait because she had to take her dentures out so she could get the mouthwash on her gums. Resident #20 indicated to LPN #1 she had sores on the left upper side of her gums. The resident pulled her lips open and showed the LPN #1 sores on the left upper part of her mouth. Interview with RN #10 on 2-14-12 at 10:16 a.m., indicated the procedure for when a resident returned from the hospital, was the discharge medication orders were usually faxed to the physician or the physician was called with the list of discharge medications. RN #10 indicated the physician had not signed the physician orders for Resident #20's medication on 1-10-12. 3.1-46(a)(1)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to provide a resident with foot care, resulting in red, dry painful feet with long thick toenails, for 1 of 1 resident sampled for foot care in a stage two sample of 15 (Resident #20). Finding include: 1.) Interview with Family member #1 and Family member #2 of Resident #20 on 2-9-12 at 2:09 p.m., indicated the resident's feet hurt her. Family member #2 indicated the resident had corns on her feet and the family had to go buy the corn removal pads to put on the resident's feet. The family members indicated the facility was not taking care of the resident's feet. Interview with Resident #20 on 2-13-12 at 9:06 a.m., indicated her feet hurt her. The resident indicated	F0328	F-328 Treatment /Care For Special Needs1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 has been seen by podiatrist on 2/14/12.2) How other residents having the potential to be affected by the same deficient practice will be identified and what correctice action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be re-educated by DNS/designee (3/6/12) on nail care and podiatry service/referal. Nail care will be completed weekly with showers and as needed. Licensed nurse will notify social services of residents identified in need of podiatry services. Social Service to schedule podiatry services for afternoon visits to accomodate all residents / staff to assist if resident declines. All residents with a signed consent will be seen by podiatry quarterly.3) What	03/15/2012

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	she had been wearing slippers due to wearing shoes made her feet hurt more. During observation on 2-13-12 at 10:10 a.m., CNA #5 took off Resident #20's socks. The resident's feet were dry, the toenails were long and thick, there was a red knot on her left foot and on the second toe on the right foot. CNA #5 indicated the resident's feet looked better today than they did last week. Review of the record of Resident #20 on 2-13-12 at 9:54 a.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), arthritis, osteoarthritis, anxiety, depression, congestive heart failure, Urinary Tract Infection (UTI), difficulty voiding and history of steroid induced hyperglycemia (high blood sugar). The Minimum Data Set (MDS) assessment for Resident #20 dated 1-17-12, indicated the following: cognitive status summary score was 15 - cognitively intact, bed mobility- extensive assistance of one person, transfer- extensive assistance of two people, walk in room- did not occur.		measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The nursing staff will be re-educated by DNS/designee (3/6/12) on nail care and podiatry service/referal. Nail care will be completed weekly with showers and as needed. Licensed nurse will notify social services of residents identifed in need of podiatry services. Social Services to schedule podiatry services for afternoon visits to accomodate all residents / staff to assist if resident declines. ADNS/SDC visual assessment monthly of all residents for appropriate nail care during monthly skin assessment.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The CQI audit tool for Accomodation of Needs will be utilized to daily x 4 weeks, bi-weekly times 2 months, and monthly x 3 months and for 3 quarters thereafter for residents receiving podiatry services. Finding from CQI process will be revieed monthly and an action plan will be implemented for threshold below 95%. Shower sheets will be reviewed daily x 2 weeks, bi-weekly x 2 months, and monthly x 3 months and quarterly thereafter for completion of nail care.Results will be reviewed monthly with IDT.5) By what date the systemic changes will be	

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	The podiatry progress note for Resident #20, dated 10-24-11, indicated the resident had onchomycosis (fungal infection on the nail). The resident had a keratoma debrided and six or more toenails debrided. The podiatry progress note for Resident #20 dated 1-4-12 indicated the resident was sleeping and woke up and stated "quit it." Interview with the Director Of Nursing (DON) on 2-13-12 at 11:30 a.m., indicated Resident #20 refused to see the podiatrist on 1-4-12. When queried if the resident was asleep would that be considered a refusal, the DON indicated the resident was on the list to see the podiatrist this month. The Social Service Director (S.S.D.) on 2-13-12 at 11:39 a.m., indicated the podiatrist usually sees residents every three months. The S.S.D. indicated Resident #20 was on the podiatry list to be seen on 2-29-12. The S.S.D. indicated the last date of service for Resident #20 was 10-24-11. Interview with the S.S.D. on 2-13-12 at 11:45 a.m. indicated she talked		complete: The corrective actions will be completed on or before 3/15/12.	

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	with the podiatrist today and he was going to come in and see Resident #20 today. The S.S.D. indicated the podiatrist who was going to see the resident was not the facility's regular podiatrist, but was a part of a group of the regular podiatrist. The S.S.D. indicated the podiatrist was going to start coming in the afternoon to see Resident #20 and also going to have him come get her before he goes and sees the resident. 3.1-47(a)(7)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to adequately monitor the administration of a medication and follow physician orders to obtain blood pressure and heart rate before administering cardiac medication, for 1 of 10 residents reviewed for medications. (Resident # 58) Findings include: On 2/08/12 at 12:30 p.m., review of	F0329	F-329 Drug Regimen Is Free From Unnecessary Drugs1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #58 blood pressure and pulse will be documented prior to administration of cardizem, based on physician order and notifying physician if holding greater than 3 days.2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All	03/15/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident # 58's Physician rewrites, dated 2/1/12 to 2/29/12, indicated Cardizem 60 mg every 6 hours, blood pressure and heart rate, hold if systolic less than 90 or heart rate less than 55. Review of the Medication Administration Records, dated 12/1/11 through 12/21/11 and 1/1/12 through 1/31/12, indicated the blood pressure and heart rate were not obtained 15 times before administration of Cardizem in December and 6 times in January. Interview with the ADON on 2/9/12 at 1:10 p.m. indicated she could find no other documentation that Resident # 58's blood pressure and pulse had been obtained on the missing dates in December and January. 3.1-48(a)(3)		residents have the potential to be affected by the alleged deficient practice. Licensed nurses will be re-educated by DNS/designee (3/6/12) on physician orders and obtaining vital signs per order prior to medication administration. All residents on medication requiring vital signs have been identified. Vital signs will be placed in MAR prior to medication administration based on physician orders and notifying physician if holding for 3 days.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed nurses will be re-educated by DNS/designee (3/6/12) on physician orders and obtaining vital signs per order prior to medication administration. All residents on medication requiring vital signs prior to medication have been identifed, monitoring per administrative nursing. Vital signs will be placed in MAR prior to medication administration, monitoring per administrative nursing.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Administrative nursing to audit daily, 5 days a week, x 2 weeks, biweekly x 2 months and monthly thereafter. Re-educate when appropriate and follow up with disciplinary action as necessary.5) By what date the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 00 B. WING	02/14/2012

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			systemic changes will be complete: The corrective actions will be completed on or before 3/15/12.	